

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01996		01991											
1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural- Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>4 days</i>		b. COUNTY <i>Calvert</i>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert County Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lusby</i>											
3. NAME OF DECEASED (Type or print) <i>David Pillsbury Allen</i>		First <i>David</i>	Middle <i>Pillsbury</i>	Last <i>Allen</i>	4. DATE OF DEATH Month <i>2</i>	Day <i>27</i>	Year <i>1967</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-25-88</i>	9. AGE (in years last birthday) <i>78 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Vermont</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Henry Selden Allen</i>		14. MOTHER'S MAIDEN NAME <i>Miriam Bean Pillsbury</i>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-07-7670</i>		17. INFORMANT <i>Mary Rolfe Allen, Lusby, Maryland</i>	Address				INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>													
443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive C. V. Disease</i>													
OUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hemiplegia for past 4 years</i>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Prince Frederick</i>		(County) <i>Maryland</i>		(State) <i>Maryland</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>2-23-67</i> , to <i>2-27-67</i> , that (I) (we) last saw the deceased alive on <i>2-27-67</i> , and that death occurred at <i>2-22-67</i> , from the causes and on the date stated above.													
22a. SIGNATURE <i>George C. Jett</i>													
22c. PHYSICIAN'S NAME (Type) <i>George C. Jett</i>		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/>		M.O. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>2-27-67</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>													
23b. DATE THEREOF <i>Feb. 28, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Cedar Hill Crematory</i>		23d. LOCATION (City, town or county) <i>Prince Frederick</i>		(State) <i>Maryland</i>							
24. FUNERAL DIRECTOR <i>A. G. Harkness & Son, Port Republic, Md.</i>		25a. REG'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE		DATE <i>MAR 1 1967</i>							

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01997

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01992

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>Salisbury</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		d. STREET ADDRESS <i>04-1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>ALVIN First MAY HUGH Middle BELT Last</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ALVIN First MAY HUGH Middle BELT Last</i>		4. DATE OF DEATH Month Day Year <i>2 24 1967</i>	
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>4/30/00</i>		9. AGE (In years last birthday) yrs. <i>86</i>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Temple Belt</i>		11. BIRTHPLACE (State or foreign country) <i>WASHINGTON, D.C.</i>	
13. FATHER'S NAME <i>TEMPLE BELT</i>		14. MOTHER'S MAIDEN NAME <i>MARY KAISER</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-09-3955</i>	
17. INFORMANT <i>MRS ANNIS OSWINKLE</i>		Address <i>8510 14th PLACE HYATTSVILLE, MD</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>7824</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Forward head down back of Calvert</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>1/22/67 2 24 1967</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>(City or town) (County) (State)</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <i>2/24/67</i>	
ACTUAL SIGNATURE <i>H. W. Ward</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) <i>H. W. Ward</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <i>BLADENSBURG, MARYLAND</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		23b. DATE THEREOF <i>27 FEB 1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>FORT LINCOLN</i>		23d. LOCATION (City or Town) (County) (State) <i>(City or Town) (County) (State)</i>	
24. FUNERAL DIRECTOR <i>W. W. Chambers Co., Riverdale, Md.</i>		25a. ADDRESS <i>ADDRESS</i>	
		25b. REC'D BY REGISTRAR DATE <i>DATE MAR 1 1967</i>	

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01998

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01993

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Calvert</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake Beach</i>		c. LENGTH OF STAY IN lb <i>10 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>Chesapeake Beach MD 20634-1001</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Florence</i>	Middle <i>Brooks</i>	Last <i>12</i>
4. DATE OF DEATH Month <i>1</i>	Month <i>2</i>	Day <i>24</i>	Year <i>1967</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED NEVER MARRIED WIDOWED DIVORCED <i>Never married</i>	8. DATE OF BIRTH <i>5/5/54</i>
9. AGE (In years last birthday) yrs. <i>12</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Food</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Horsey Brooks</i>	14. MOTHER'S MAIDEN NAME <i>Edward Jones</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>493-8</i>
17. INFORMANT <i>Horsey Brooks Mrs. Edward Jones</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart attack</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Never walked a block</i> DUE TO (c) <i>Never walked a block</i>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED <i>2/25/67</i>		23. MEDICAL CERTIFICATION ACTUAL SIGNATURE <i>H. W. Ward</i> M.D. EXAMINER'S NAME (Type)	
23a. BURIAL OR CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>2-26-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Edmonds Ch. Cem.</i>	23d. LOCATION (City or Town) (County) (State) <i>Calvert Co. Md.</i>
24. FUNERAL DIRECTOR <i>Pinkney E. Sewell Prince Frederick</i>	ADDRESS <i>6M 1/66</i>	25a. REC'D BY REGISTRAR DATE <i>FEB 28 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Calvert			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick			c. LENGTH OF STAY IN 1b 32 days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First James	Middle Eugene	Last Copsey	4. DATE OF DEATH 2
S. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9-23-80	9. AGE (In years last birthday) 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James Levi Copsey			14. MOTHER'S MAIDEN NAME Zora Ann Wood		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-05-9633		17. INFORMANT Mrs. George T. Horsman, Jr. Md.	
Address Waldorf, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>acute</u> DUE TO <u>conway the bulges.</u> stating the underlying cause (c) <u></u>					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>Prince Frederick</u> (County) <u>Maryland</u> (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 5, 1967</u> , to <u>Feb. 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb. 6, 1967</u> , and that death occurred at <u>7:20 AM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Issam F. el Damalouji, M.D.</u>					
22b. DATE SIGNED <u>2-6-67</u>					
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Prince Frederick, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Feb. 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Old Fields</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Herkhurt Funeral Home, Waldorf, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01995

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>	c. LENGTH OF STAY IN 1D c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert</i>	d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Edward Ford</i>	First <i>Edward</i>	Middle <i>Frederick</i>	Last <i>Ford</i>	4. DATE OF DEATH <i>2 27 1967</i>	Month Day Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 25 1917</i>	9. AGE (in years last birthday) <i>50 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>None</i>
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13. FATHER'S NAME <i>Edward Ford</i>	14. MOTHER'S MAIDEN NAME <i>None Conley</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>220-46-8208</i>	17. INFORMANT <i>By wife & daughter</i>	Address <i>104 W. Main St. Frederick Md.</i>

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>7824</i>	DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)	DUE TO (b) (c)	INTERVAL BETWEEN ONSET AND DEATH <i></i>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Had mild cold at time</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i></i>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10/15 p.m. 227 67	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>Frederick (Md.) Md.</i>

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>H. W. Smith</i>	M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <i></i>	22. DATE SIGNED <i>2/27/67</i>
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ACTUAL SIGNATURE <i>H. W. Smith</i>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <i></i>	Address (Street, city, town, or county) <i></i>
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EXAMINER'S NAME (Type) <i></i>	23a. BURIAL/CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>3-4-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cooper's church cem.</i>	23d. LOCATION (City, town or county) (State) <i>Calvert co. Md.</i>
24. FUNERAL DIRECTOR <i>Linkney E. Lovell - Prince Frederick, Md.</i>	ADDRESS <i></i>	25a. REC'D BY REGISTRAR <i></i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE MAR 2 1967

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02001

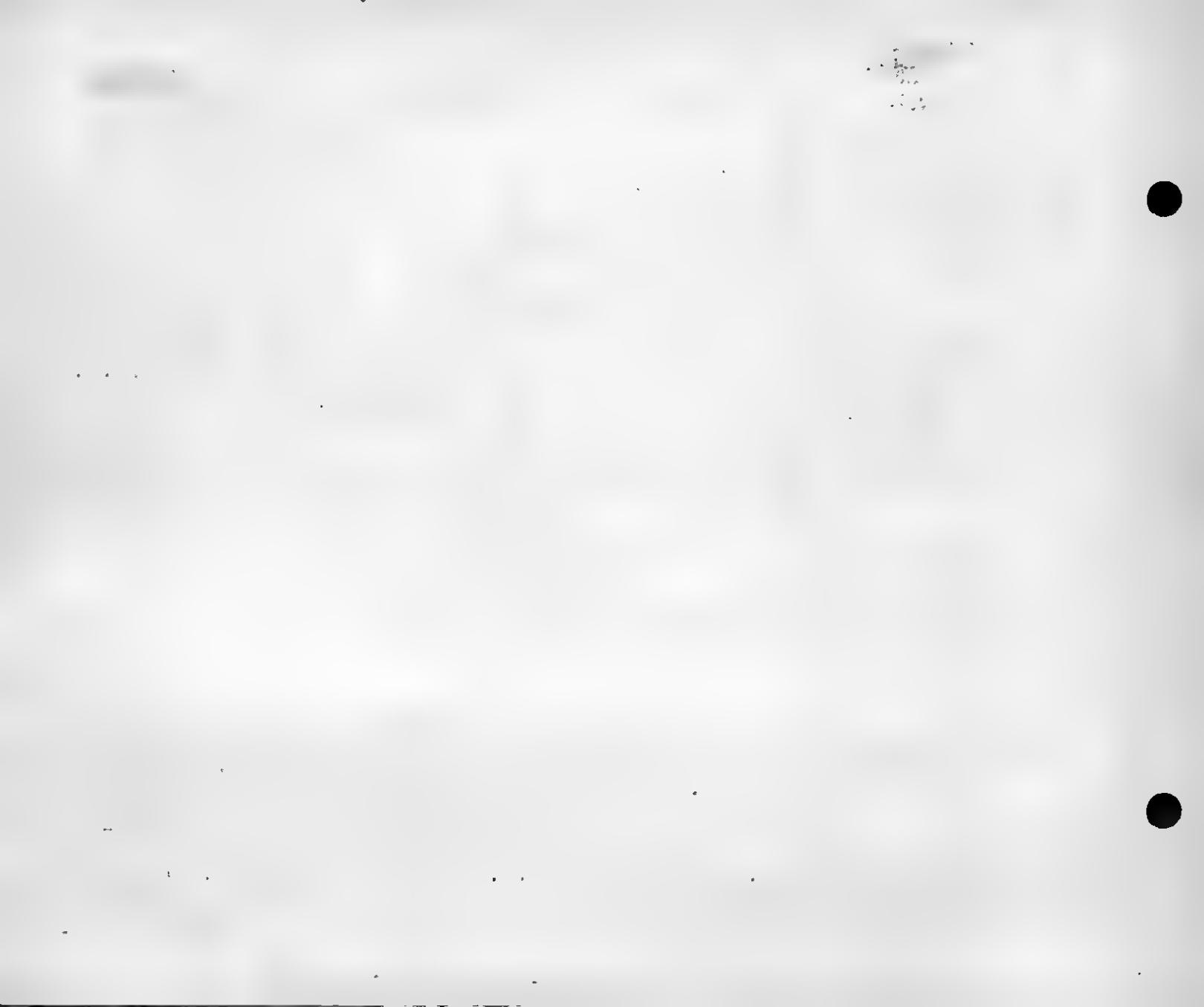
CERTIFICATE OF DEATH

01996

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick		c. LENGTH OF STAY IN lb 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		e. STREET ADDRESS Olivet	
3. NAME OF DECEASED (Type or print) Rosie Buck Howard		4. DATE OF DEATH Last Month Day Year 2 9 19 67	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX female	6. COLOR OR RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-12-12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 54 yrs.
13. FATHER'S NAME James Buck		11. BIRTHPLACE (County & State, or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO	12. CITIZEN OF WHAT COUNTRY? U.S.A.
17. INFORMANT		Address Joshua Howard Olivet, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>C. V. A.</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Housewife - Housewife		DUE TO (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Prince Frederick, Maryland
20f. (City or town) Prince Frederick		(County) (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from Feb. 6, 1967 , to Feb. 9, 1967 , that (I) (we) last saw the deceased alive on Feb. 9, 1967 , and that death occurred at 7:30 P.M. from causes and on the date stated above.		22b. DATE SIGNED 2-10-67	
22a. SIGNATURE <i>Issam F. el Damalouji, M.D.</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Issam F. el Damalouji, M.D.		22d. ADDRESS Prince Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) 2-12-67		23b. DATE THEREOF 2-12-67	23c. NAME OF CEMETERY OR CREMATORIAL Eastern Chapel Crem. Cen.
24. FUNERAL DIRECTOR Pinkney E. Sewell		ADDRESS Pr. Frederick, Md.	25a. REC'D BY REGISTRAR 1-14-1967
			25b. REGISTRAR'S SIGNATURE <i>James George</i>



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02002

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01997

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased resided, if institution, residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Calvert</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i> d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Frederick Joseph Hurnley</i>		First <i>F</i>	Middle <i>J</i>	Last <i>Hurnley</i>	4. DATE OF DEATH Month <i>2</i> Day <i>12</i> Year <i>1967</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/11/01</i>	
10a. US LAB OCCUPATION (One kind of work done during most of working life, even if retired) <i>Appliance repairman</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
13. FATHER'S NAME <i>Joseph Hurnley</i>		14. MOTHER'S MAIDEN NAME <i>Maggie Freeman</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>216-12-5448</i>		17. INFORMANT <i>Susie Purvey-Sunderland, md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Froze to death</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Had frostbites, see info in b</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Had frostbites, see info in b</i>		20c. TIME OF INJURY Month, Day, Year Hour <i>a.m.</i> <i>pm</i> <i>3/11/67</i>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>Prince Frederick, md</i>		20f. (City or town) <i>Prince Frederick</i> (County) <i>Calvert Co.</i> (State) <i>MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>It is a copy</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <i>2-3-67</i>	
EXAMINER'S NAME (Type) <i>Charles Judge</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) <i>Charles Judge</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2-15-67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Patuxent Ch. Cem.</i>	
23d. LOCATION (City or Town) <i>Calvert Co.</i> (County) <i>MD</i> (State)		23e. REC'D BY REGISTRAR <i>Charles Judge</i>		23f. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
24. FUNERAL DIRECTOR <i>Pinkney E. Sewell</i>		ADDRESS <i>Prince Frederick, md.</i>		DATE <i>FEB 17 1967</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01998

1 FOR STATE
HEALTH DEPT.

02003

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

1 PLACE OF DEATH a COUNTY <i>Charles</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a STATE <i>1016</i> b COUNTY <i>Charles</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Charles</i>		c LENGTH OF STAY IN lb <i>2742</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Charles C. Hospital</i>		e STREET ADDRESS <i>Charles</i>	
3 NAME OF DECEASED (Type or print) <i>Thomas Wilson Jackson</i>		4. DATE OF DEATH Month <i>2</i> Day <i>14</i> Year <i>1967</i>	
5 SEX <i>M</i>	6 COLOR OR RACE <i>C</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>10-23-1900</i>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Delivery man</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
13. FATHER'S NAME <i>Benjamin Jackson</i>		14. MOTHER'S MAIDEN NAME <i>Laura Jane Hicks</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>705-12-3868</i>	
17. INFORMANT <i>Her children</i>		Address <i>1102 L. Jane Hicks, Charles, Md. 21628</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Heart disease</i>			
DUE TO (b) <i>Heart disease</i>			
DUE TO (c) <i>Heart disease</i>			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter method of injury in Part I or Part II of Item 18) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year <i>3 p.m. 24 1967</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) (County) (State) <i>Charles, Md. Charles, Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect'an <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles Jackson</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county)		22. DATE SIGNED <i>2/14/67</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>2-18-67</i>		23b. DATE THEREOF <i>2-18-67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Moses Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Bristol, Md. A.A. Md.</i>	
24. FUNERAL DIRECTOR <i>Charles Jackson</i>		25a. RECEIVED BY REGISTRAR <i>Charles Jackson</i>	
ADDRESS		25b. REGISTRAR'S SIGNATURE	
DATE FEB 21 1967		Charles Jackson	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

M

02004

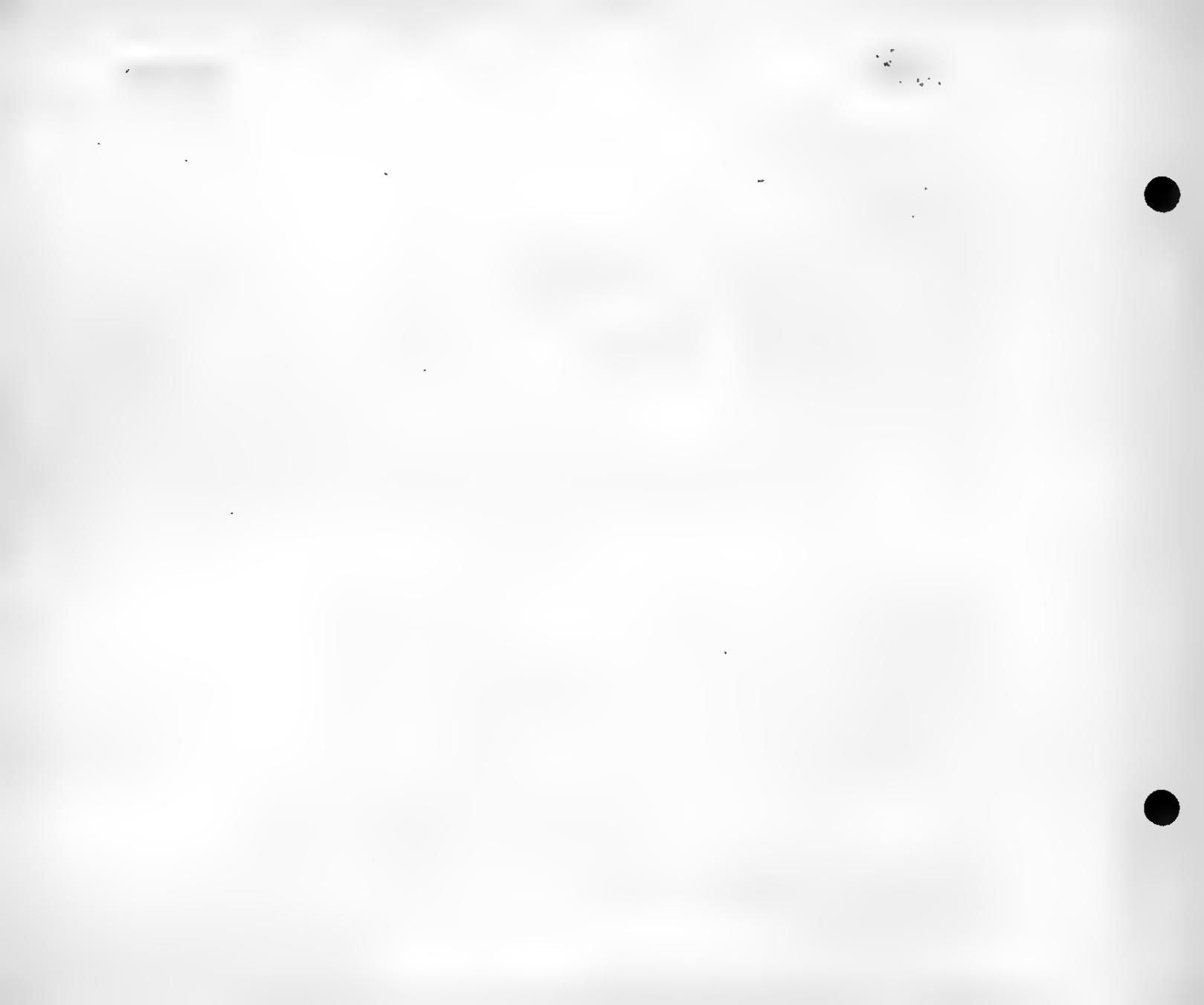
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01899

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in Items 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and bury event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
<i>Calvert Co</i>		<i>MD</i>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)	
<i>Opposite Frederick 000</i>		<i>Broomes Island Md</i>	
d. LENGTH OF STAY IN 1b		e. STREET ADDRESS	
<i>Calvert Co</i>		<i>—</i>	
f. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Calvert Co</i>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>John</i>	<i>Emerson</i>	<i>James</i>	<i>Jones</i>
4. DATE OF DEATH	Month	Day	Year
<i>7/17/67</i>	<i>7</i>	<i>17</i>	<i>67</i>
5. SEX	6. COLOR OR RACE	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED
<i>Male</i>	<i>White</i>	<input type="checkbox"/>	<input type="checkbox"/>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. KIND OF BUSINESS OR INDUSTRY	
<i>Rancher</i>		<i>Station</i>	
12. CITIZEN OF WHAT COUNTRY?		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>George Jones</i>		<i>Delcie Bennett</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>Yes</i>		<i>213-22-1825</i>	
17. INFORMANT		Address	
<i>Hospital Records</i>		<i>—</i>	
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) lost			
DUE TO (c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
20a. TIME OF INJURY Month, Day, Year Hour		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 1 of item 18)	
<i>12 40 p.m. 2/7 1967</i>		<i>While at work</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		<i>Calvert Co</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED <i>2/7/67</i>			
ACTUAL SIGNATURE <i>H. W. Ward</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. W. Ward M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. W. Ward M.D.</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE THEREOF	
<i>Burial</i>		<i>Feb. 11, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town) (County) (State)	
<i>Water Memorial Cemetery</i>		<i>Island Creek, Calvert, Md.</i>	
24. FUNERAL DIRECTOR ADDRESS		25a. REC'D BY REGISTRAR	
<i>A. A. Harbrace & Son, Rock Republic, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>FEB 10 1967</i>			



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2 CERTIFICATE OF DEATH

3 02005

4 02000

1. PLACE OF DEATH
a. COUNTY

Calvert

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural-Prince Frederick 1 day

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE

Maryland

b. COUNTY

Calvert

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

North Beach

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?

YES NO

59

3. NAME OF
DECEASED
(Type or print)

First Louise

Middle Riddle

Last Lanham

4. DATE
OF
DEATH

2

21

19 67

5. SEX

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

2-10-22

9. AGE (in years
last birthday)

45

yrs.

10. IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

housewife

10b. KIND OF BUSINESS OR
INDUSTRY

Domestic

11. BIRTHPLACE (County & State, or foreign country)

District of Columbia

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

Cleveland Riddle

14. MOTHER'S MAIDEN NAME

Elizabeth Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

NO

16. SOCIAL SECURITY NO.

578-22-9988

17. INFORMANT

Richard E. Lanham

Address

North Beach, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).1

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which
gave rise to Immediate
cause (a), stating the
underlying cause last.

DUE TO

(b)

DUE TO

(c)

Circulatory collapse

Generalized carcinomatosis

INTERVAL BETWEEN
ONSET AND DEATH

22a. MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

While
at work

Not While
at work

19. WAS AUTOPSY
PERFORMED?

YES NO

21. I certify that (I) (this hospital) attended the deceased from Feb. 23, 1967, to Feb. 24, 1967, that (I) (we) last
saw the deceased alive on Feb. 24, 1967, and that death occurred at 7:20 AM, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

Osman Z. Ersoy, M.D.

M.D.
ATTENDING
PHYS.

MED.
DIRECTOR
STAFF
PHYS.

22b. DATE SIGNED

2-24-67

22d. ADDRESS

Prince Frederick, Maryland

23a. BURIAL, CREMATION, REMOVAL
(Specify)

Burial

23b. DATE THEREOF

Feb. 27, 1967

23c. NAME OF CEMETERY OR CREMATORIUM

Christian Brothers Cem.

23d. LOCATION (City, town or county) (State)

Beltsville, Maryland

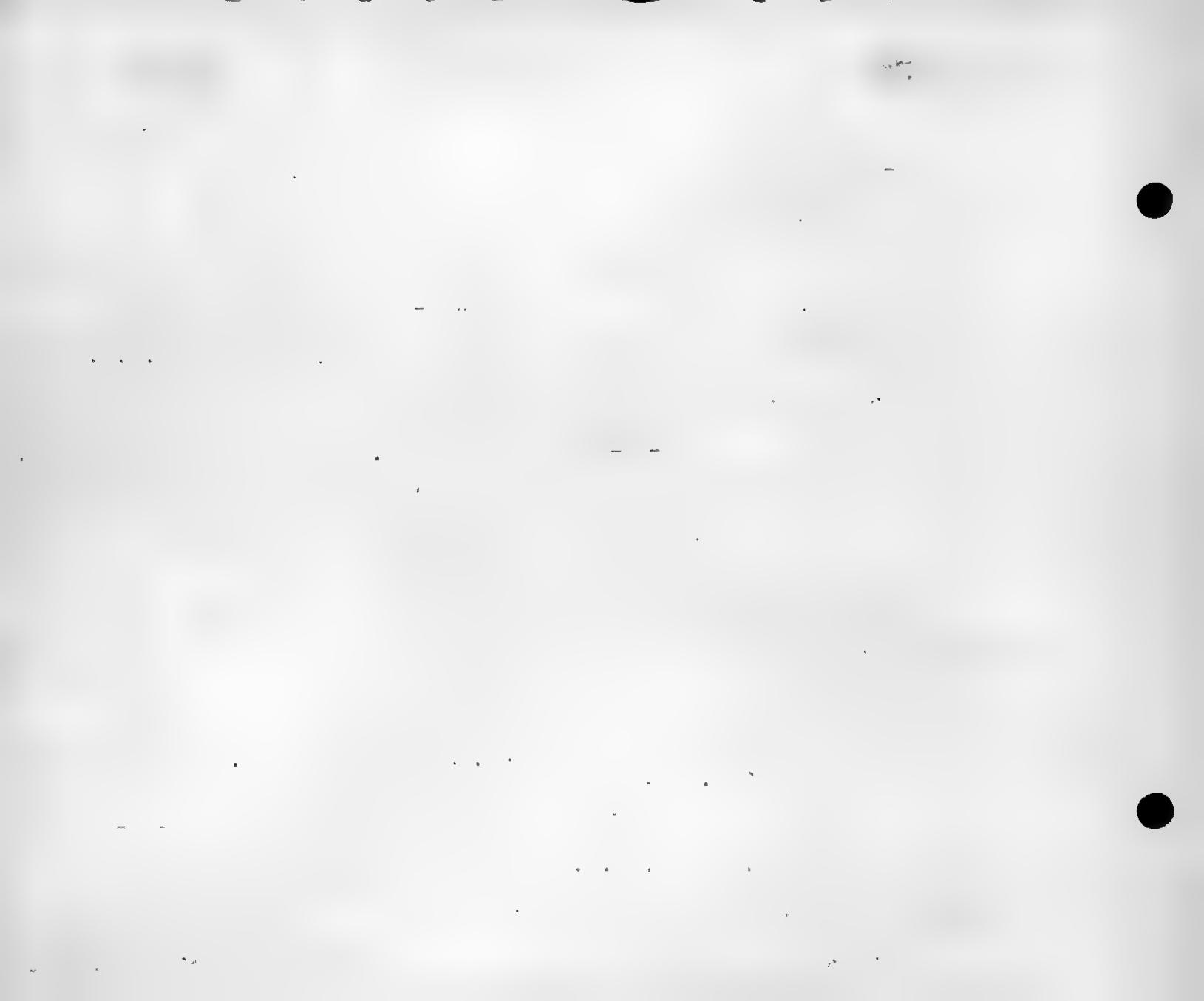
24. FUNERAL DIRECTOR

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Hutchins Funeral Home (Loring, Md.) DATE FEB 28 1967 Charles Judge



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02006

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02001

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If City day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Calvert</i>		2 USUAL RESIDENCE (Where deceased resided, if institution, Residence before admission) a. STATE <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>1 month</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert Co. H.</i>		e. STREET ADDRESS <i>Island Creek Rd.</i>	
3 NAME OF DECEASED (Type or print) <i>John E. Sawyer</i>		4 DATE OF DEATH <i>May 21 1967</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
S SEX <i>M</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	8 NEVER MARRIED DIVORCED <input checked="" type="checkbox"/> <input type="checkbox"/>
9a. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gas</i>		9b. DATE OF BIRTH <i>May 23 1937</i>	
9c. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>		9d. AGE (In years last birthday) <i>30 yrs</i>	
10. FATHER'S NAME <i>John R. Mason</i>		11. BIRTHPLACE (State or foreign country) <i>U. S. A.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. MOTHER'S MAIDEN NAME <i>Lawrence Johnson</i>	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		15. SOCIAL SECURITY NO <i>217-34-1252</i>	
16. INFORMANT <i>Lawrence Johnson</i>		17. ADDRESS <i>Island Creek Rd.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>8164</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Fracture - left leg</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
DUE TO (b) <i>Fracture - left leg</i>		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>fall in icy area</i>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <i>Fracture - left leg</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Fracture - left leg</i>	
20c. TIME OF INJURY Month, Day, Year <i>May 21 1967</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input checked="" type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office, bridge, etc.) <i>Island Creek Rd.</i>
20f. (City or town) <i>Calvert Md.</i>		(County) (State) <i>Calvert Md.</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H. W. L. C. M.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>Island Creek C. C. Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Island Creek C. C. Md.</i>		23b. DATE THEREOF <i>2-19-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Brooks C. Cemetery</i>
23d. LOCATION (City or Town) <i>Island Creek C. C. Md.</i>		(County) (State) <i>Calvert Md.</i>	
24. FUNERAL DIRECTOR <i>Lawrence E. Sawyer, Esq., Frederick, Md.</i>		25a. ADDRESS <i>Island Creek C. C. Md.</i>	
25b. REC'D BY REGISTRAR <i>2-21-67</i>		25b. REGISTRAR'S SIGNATURE <i>Lawrence E. Sawyer, Esq., Frederick, Md.</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02007

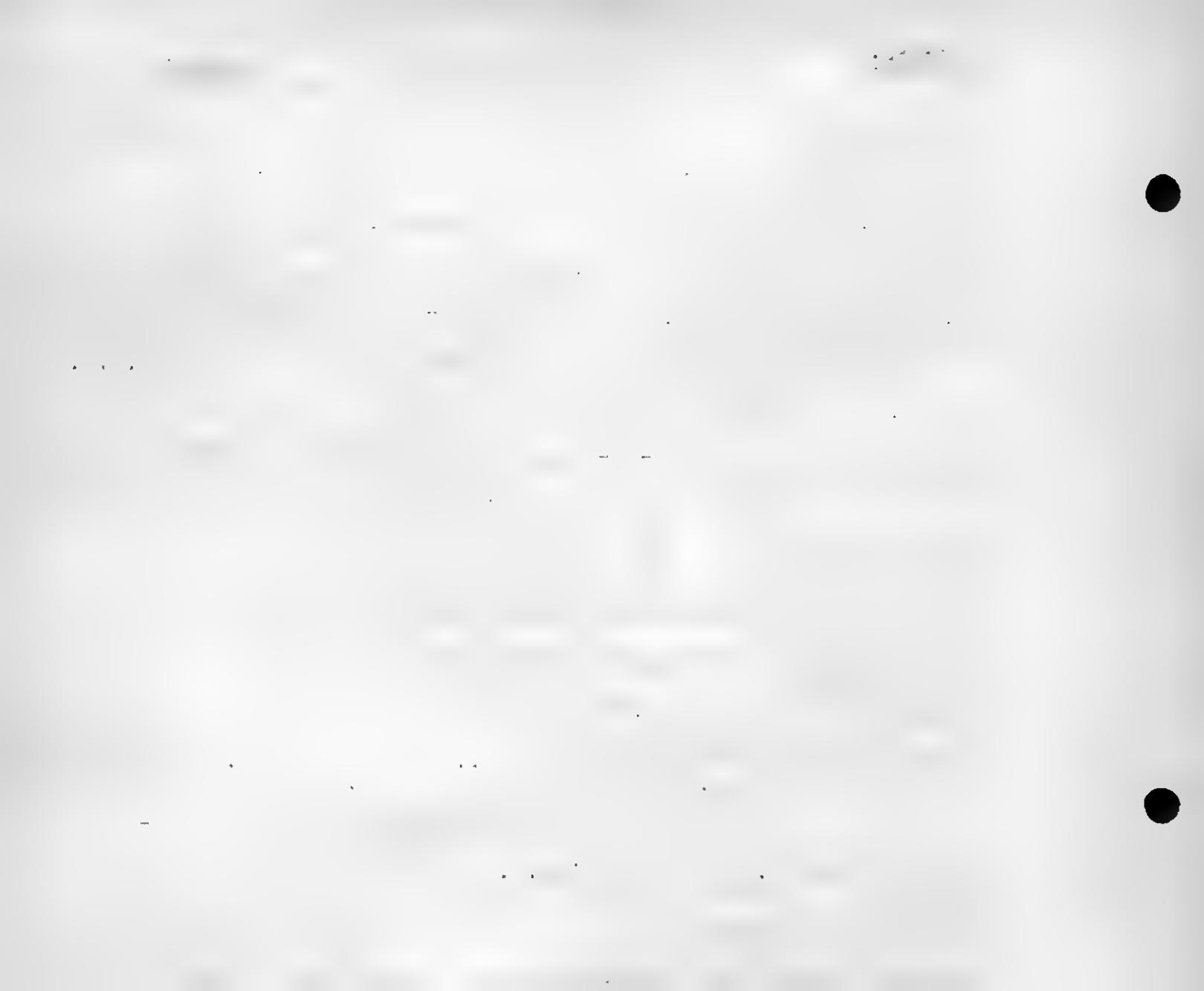
CERTIFICATE OF DEATH

02002

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick 1 day		c. LENGTH OF STAY IN lb 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Sinclair	Middle Robert	Last Monroe
4. DATE OF DEATH Month 2	Month 21	Day 19	Year 67
5. SEX male	6. COLOR OR RACE negro	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 2-10-95	9. AGE (In years last birthday) 72 yrs.	10. UNDER 1 YEAR Months 0	11. UNDER 24 HRS Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Cobb	14. MOTHER'S MAIDEN NAME Winnie Ann Monroe	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service 1814	
16. SOCIAL SECURITY NO. 218-14-2154	17. INFORMANT Florence Monroe	Address same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1814 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) old age DUE TO last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 23, 1967 , to Feb. 24, 1967 that (I) (we) last saw the deceased alive on Feb. 24, 1967 , and that death occurred at 1:20 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Issam F. el Damalouji, M.D.</i>	M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2-24-67	
22c. PHYSICIAN'S NAME (Type) Issam F. el Damalouji, M.D.	22d. ADDRESS Prince Frederick, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-27-67	23c. NAME OF CEMETERY OR CREMATORIAL St. Philip's Ch. Cem.	23d. LOCATION (City or Town) (County) (State) Aquasco, Prince George's, Md.
24. FUNERAL DIRECTOR Marcell Adams	ADDRESS Aquasco, Md.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE
20 A15 14 20 M 1/66		DATE MAR 1 1967	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATEMENT
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiners Office along with form PM3 Page 5 may be retained for your files.

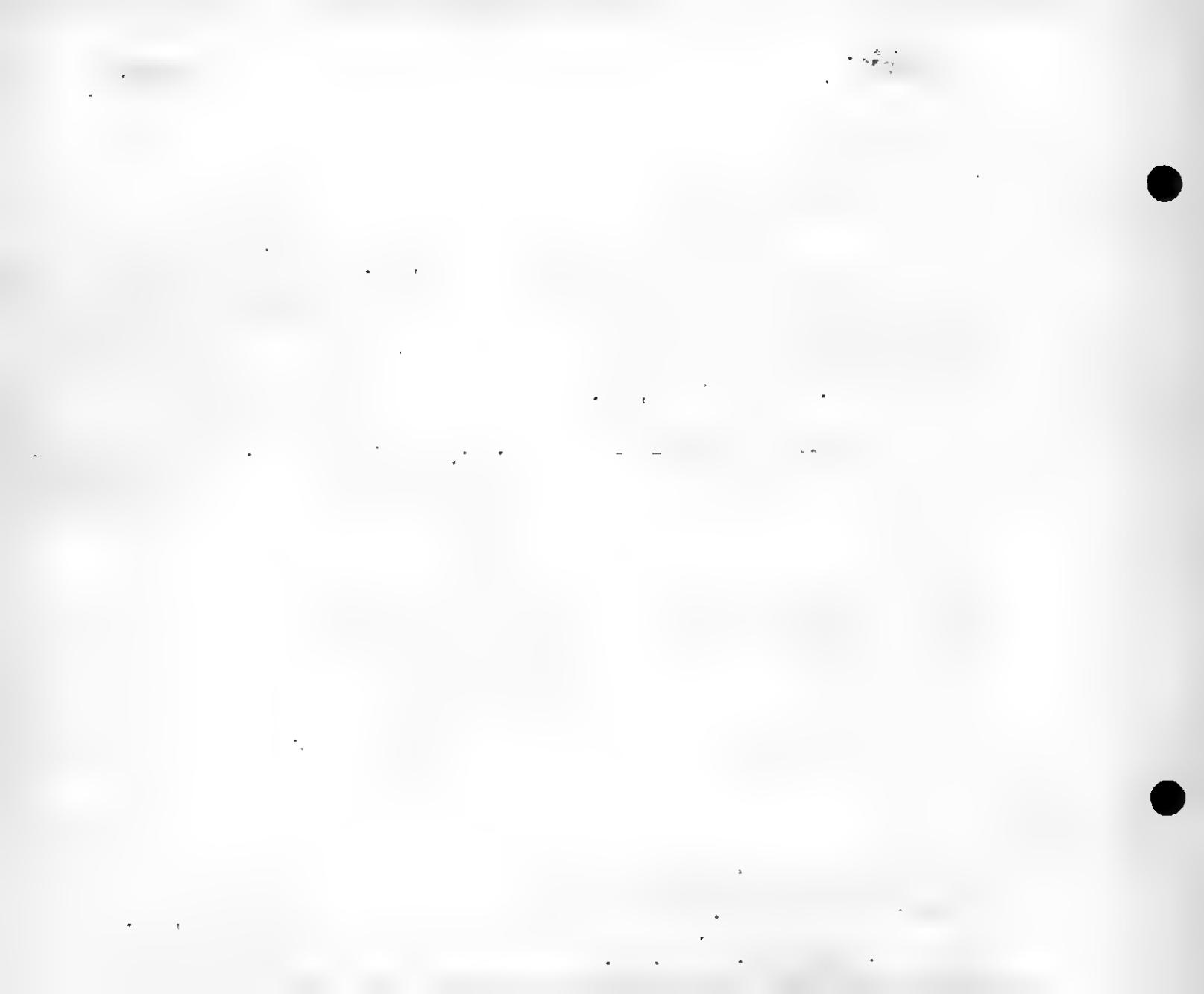
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1, 2 and 4 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02008

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
<i>Calvert</i> Md.		<i>Old Laurel</i> Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Alto Hotel</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William Taylor</i>		First <i>W</i>	Middle <i>L</i>
4. DATE OF DEATH Month <i>2</i>		Year <i>1967</i>	Day <i>7</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Employee of Eastern Airlines</i>		9. DATE OF BIRTH <i>3/27/35</i>	
10. KIND OF BUSINESS OR INDUSTRY <i>Employee of Eastern Airlines</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>W. Taylor Pierce, Sr.</i>	
14. MOTHER'S MAIDEN NAME <i>Hedwig Miller</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <i>Yes</i> <i>Korean</i>	
16. SOCIAL SECURITY NO. <i>215-32-4336</i>		17. INFORMANT Address <i>Mr. W. Taylor Pierce Sr. 924 North Hill Rd.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>9166</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a) <i>Probably due to cigarette in bed at Alto Hotel, MD</i>	
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1b) <i>Was seen at bar at 11 pm</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>2/25 1967</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bus, etc.) <i>Alto Hotel</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <i>2/7/67</i>	
ACTUAL SIGNATURE <i>H. W. Ward</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>M. W. Ward</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2/10/67.</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Gardens of Faith Cemetery</i>
23d. LOCATION (City or Town) <i>Baltimore, Md.</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>		ADDRESS <i></i>	25a. REC'D BY REGISTRAR <i></i>
		25b. REGISTRAR'S SIGNATURE <i></i>	DATE <i>FEB 8 1967</i> <i>W. W. Ward</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02009

CERTIFICATE OF DEATH

02004

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, entombment, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Calvert		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rawlings		First	Middle
4. DATE OF DEATH February 4, 1967	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH 2-2-67		9. AGE (In years lost birthday) IF UNDER 1 YEAR Months 2 Days 0 Hours 0 Min. 0	
10. JEWISH OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State or foreign country) Maryland	
13. FATHER'S NAME Sylvester Simms		14. MOTHER'S MAIDEN NAME Mary Jane Rawlings	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother- Owings, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pre-mature DUE TO Conditions, if any, which gave rise to immediate cause (a) (b) stating the underlying cause lost. (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) Huntingtown (County) Cal. Md. (State)			
21. I certify that (I) (this hospital) attended the deceased from Feb. 2, 1967 to Feb. 4, 1967 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE <i>George J. Weems</i>		22b. DATE SIGNED 2-4-67	
22c. PHYSICIAN'S NAME (Type) George J. Weems, M. D.		22d. ADDRESS Huntingtown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) 2-5-67		23b. DATE THEREOF 2-5-67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Hope C.C.		23d. LOCATION (City or Town) (County) (State) Sunderland Cal. Md.	
24. FUNERAL DIRECTOR Pinkney E. Secord, Prince Fred.		25a. ADDRESS 1161	
		25b. REC'D BY REGISTRAR DATE FEB 9 1967	
		25b. REGISTRAR'S SIGNATURE <i>Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division
02010

CERTIFICATE OF DEATH

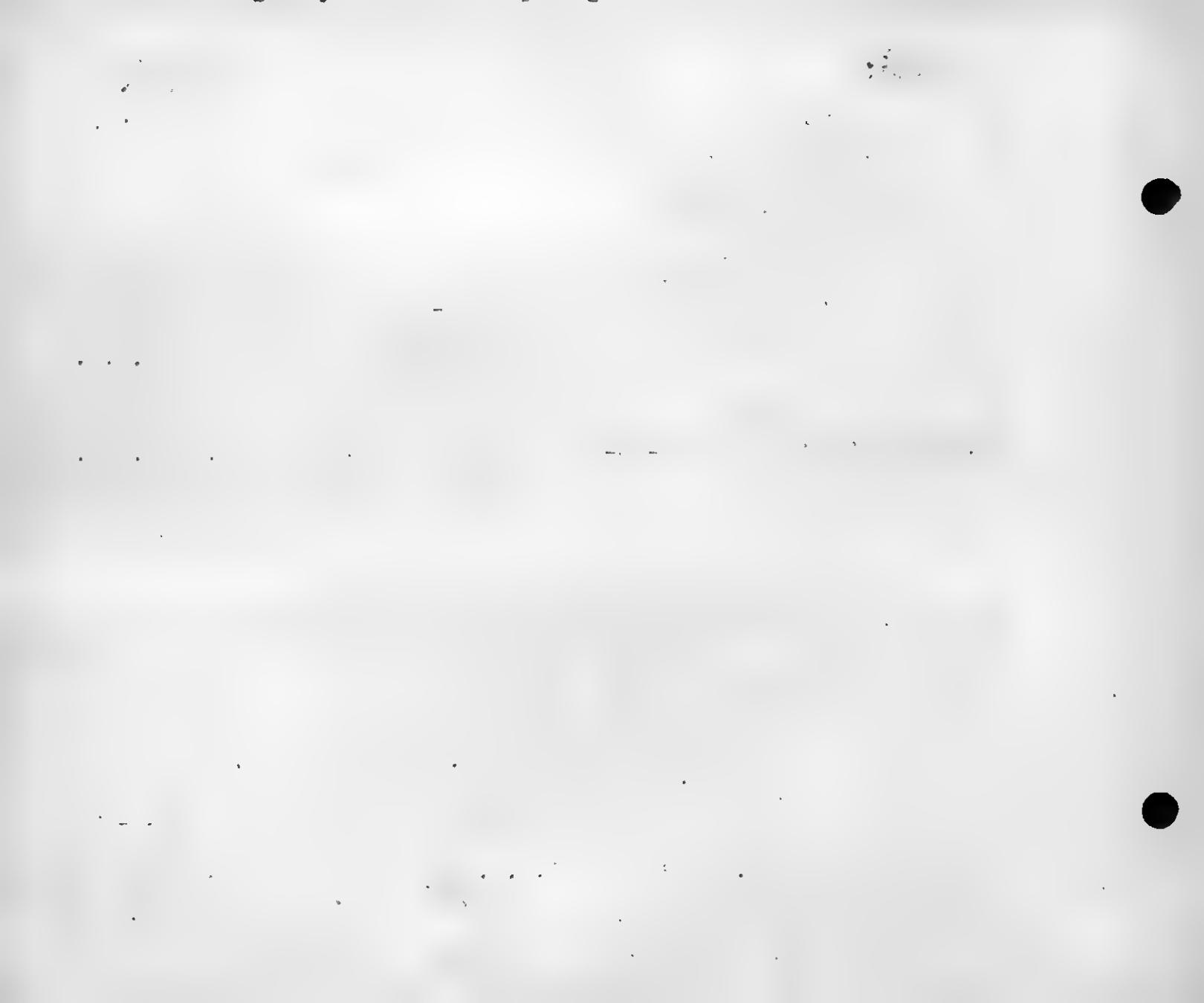
02005

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Calvert		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Prince Frederick		c. LENGTH OF STAY IN 1b 37 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendship	
3. NAME OF DECEASED (Type or print) Edwin Webb		4. DATE OF DEATH 2	D. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6-7-1900
10a. USUAL OCCUPATION (Clue kind of work done during most of working life, even if retired) farmer		9. AGE (In years last birthday) 66 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 2 Days 2 Hours 19 Min. 67
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Edward Sansbury		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. W. W. I	17. INFORMANT Address 212-36-7560 Hester Sansbury Friendship, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 15'X		INTERVAL BETWEEN ONSET AND DEATH Calverton - Powell	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart disease.		DUE TO (c) Heart disease.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Friendship		(County) Md. (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 27, 1967 , to Feb. 2, 1967 , that (I) (we) last saw the deceased alive on Feb. 2, 1967 , and that death occurred at 12:10 PM , from the causes and on the date stated above.			
22a. SIGNATURE <i>awed</i>		22b. DATE SIGNED 2-2-67	
22c. PHYSICIAN'S NAME (Type) Issam F. el Damalouji, M.D.		22d. ADDRESS Prince Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 4, 1967	
23c. NAME OF CEMETERY OR CREMATORY Friendship Ch. Cem		23d. LOCATION (City, town or county) Friendship, Md.	
24. FUNERAL DIRECTOR Hutchinson Funeral Home Owings, Md.		25a. REC'D BY REGISTRAR DATE FEB 8 1967	
25b. REGISTRAR'S SIGNATURE <i>W. W. I.</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02011

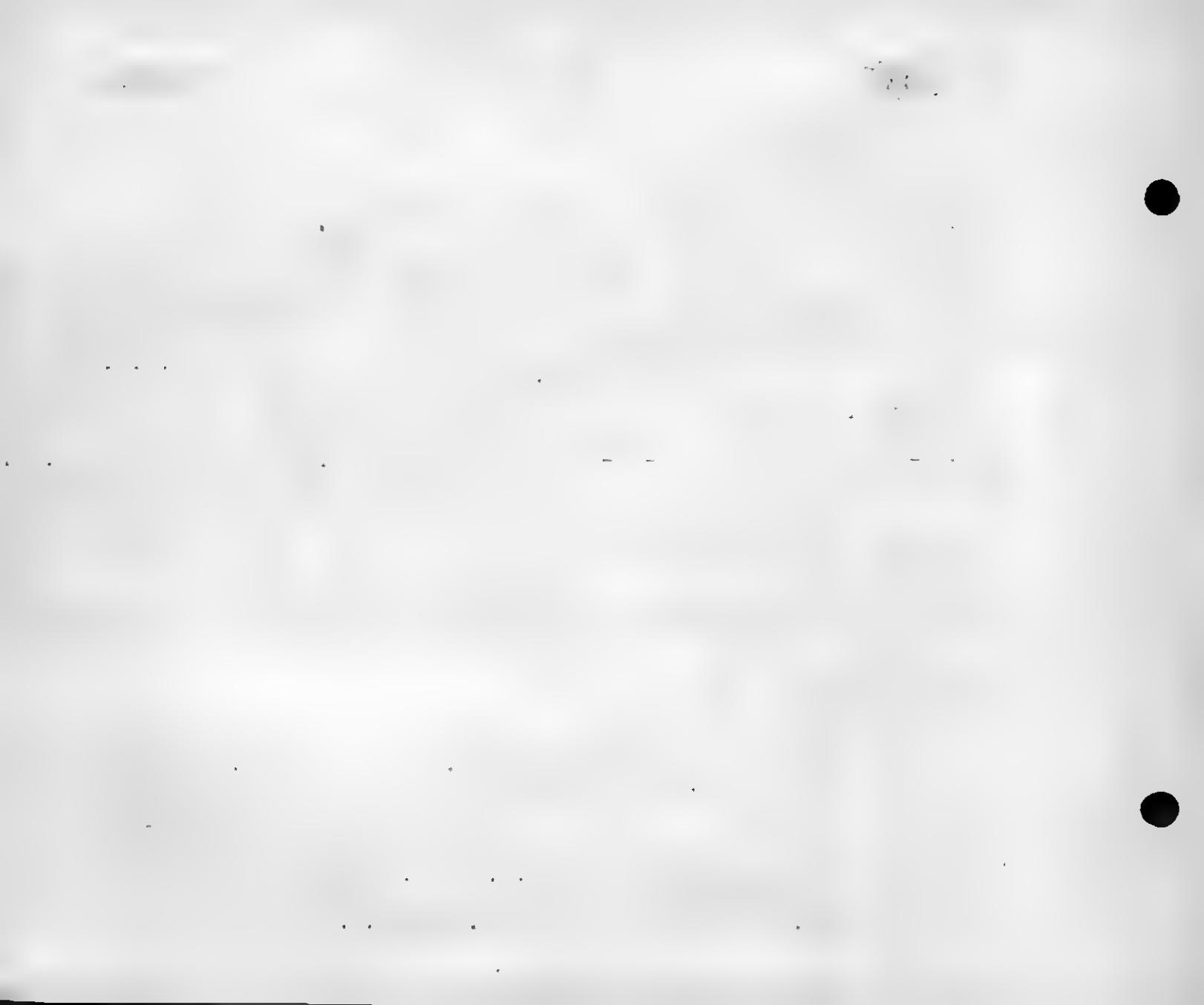
CERTIFICATE OF DEATH

02006

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Calvert		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick			c. LENGTH OF STAY IN 1b 4 days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital			e. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Chesapeake Beach		
f. STREET ADDRESS Box 206, C Street			g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
h. NAME OF DECEASED (Type or print) Ernest James Shumaker			i. DATE OF DEATH 2 16 1967		
j. SEX male			k. COLOR OR RACE white		
l. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			m. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
n. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			o. KIND OF BUSINESS OR INDUSTRY Conductor (Transit Co.)		
p. BIRTHPLACE (County & State, or foreign country) Virginia			q. AGE (In years last birthday) 72 yrs		
r. CITIZEN OF WHAT COUNTRY? U.S.A.			s. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0		
t. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0			u. FATHER'S NAME Robert R. Shumaker		
v. MOTHER'S MAIDEN NAME Evelyn Cooper			w. ADDRESS Elsie Shumaker Chesapeake Beach, Md.		
x. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown WWI			y. SOCIAL SECURITY NO. 578-10-5261		
z. INFORMANT Elsie Shumaker			aa. INTERVAL BETWEEN ONSET AND DEATH 4 21 1		
bb. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 21 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO stating the underlying cause (c) 			cc. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 		
dd. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			ee. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		
ff. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			gg. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
hh. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) 			ii. (City or town) (County) (State) 		
jj. I certify that (I) (this hospital) attended the deceased from Feb. 12, 1967 , to Feb. 16, 1967 , that (I) (we) last saw the deceased alive on Feb. 16, 1967 , and that death occurred at 3:30 AM , from causes and on the date stated above.			kk. DATE SIGNED 2-16-67		
ll. SIGNATURE Roberto de Villarreal, M.D.			mm. ATTENDING PHYS <input checked="" type="checkbox"/>		
nn. PHYSICIAN'S NAME (Type) Roberto de Villarreal, M.D.			oo. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
pp. ADDRESS St. Leonard, Maryland			qq. ADDRESS Hutchins Funeral Home Owings, Md.		
rr. BURIAL, CREMATION, REMOVAL (Specify) Burial			ss. DATE THEREOF Feb. 18, 1967		
tt. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cem. Wash.D.C.			uu. LOCATION (City or Town) (County) (State) 		
vv. FUNERAL DIRECTOR Hutchins Funeral Home			ww. RECED BY REGISTRAR 		
xx. ADDRESS Owings, Md.			yy. DATE FEB 20 1967		
zz. REGISTRAR'S SIGNATURE Charles Jester					



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

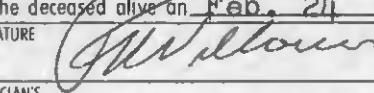
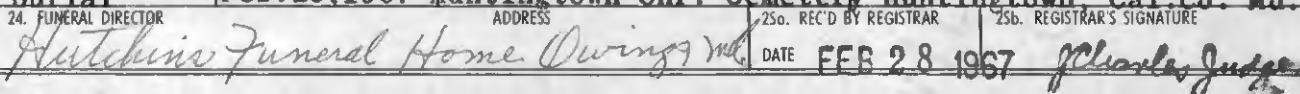
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02012

CERTIFICATE OF DEATH

02007

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick		c. LENGTH OF STAY IN 1b 86 days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Samuel		First Ellsworth	Middle Trott	
4. DATE OF DEATH Month 2 Day 24 Year 1967	5. SEX male	6. COLOR OR RACE white	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2-12-81		9. AGE (In years last birthday) 86 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John B. Trott		14. MOTHER'S MAIDEN NAME Martha Fowler		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or if unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 218-36-5324 17. INFORMANT Lillian Humphreys Address Dowell, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1977 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Ca of Prostate (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) St. Leonard (County) Maryland (State)
21. I certify that (I) (this hospital) attended the deceased from Nov. 30 , 1966, to Feb. 24 , 1967, that (I) (we) last saw the deceased alive on Feb. 24 , 1967, and that death occurred at 7:20aM, from causes and on the date stated above.				22b. DATE SIGNED 2-24-67
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Roberto de Villarreal, M.D. St. Leonard, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 26, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Huntington Chr. Cemetery	23d. LOCATION (City or Town) Huntington (County) Cal. Co. Md. (State)
24. FUNERAL DIRECTOR 		ADDRESS Hutchins Funeral Home, Owings Mills	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02013

CERTIFICATE OF DEATH

02008

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick			c. LENGTH OF STAY IN lb 9 hrs.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake Beach		
f. STREET ADDRESS			g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Walter T. Ward			4. DATE OF DEATH Month 2 Doy 12 Year 1967		
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-18-91	9. AGE (In years last birthday) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rent labor			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Perry Ward			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 220-05-4250		
17. INFORMANT Wilton Ward			Address Chesapeake Beach, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertension CVD</i>					
442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) (c)					
DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
DUE TO DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Doy, Year Hour o.m. 19					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) Huntingtown (County) Calvert Co. (State) Md.					
21. I certify that (I) (this hospital) attended the deceased from Feb. 12, 1967 , to Feb. 12, 1967 , that (I) (we) last saw the deceased alive on Feb. 12, 1967 , and that death occurred at 9:25 AM , from causes and on the date stated above.					
22a. SIGNATURE <i>George J. Weems</i>					
22b. DATE SIGNED 2-13-67					
22c. PHYSICIAN'S NAME (Type) George J. Weems, M.D.					
22d. ADDRESS Huntingtown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)					
23b. DATE THEREOF 2/16/67					
23c. NAME OF CEMETERY OR CREMATORIAL St. Edmonds Ch. Cem.					
23d. LOCATION (City or Town) Calvert Co. (County) Md. (State)					
24. FUNERAL DIRECTOR Pinkney E. Sewell					
ADDRESS Prince Frederick, Md.					
25a. REC'D BY REGISTRAR					
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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